STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385201	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Post Acute	707 SW 37th Street Pendleton, OR 97801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review it was determined the facility failed to ensure residents were assessed for safe self-administration of medications for 3 of 3 sampled residents (#'s 31, 35 and 46) reviewed for self-administration of medications. This placed residents at risk for unsafe medication administration and adverse medication side effects. Findings include: 1. Resident 35 was admitted to the facility in 5/2023 with diagnoses including dementia. Resident 35’s 5/19/25 Annual MDS indicated the resident had moderate cognitive impairment. Observations on 8/18/25 at 11:02 AM and 8/19/25 at 8:45 AM revealed Resident 35 had antifungal powder and antifungal lotion on her/his bedside table. Review of Resident 35’s health record revealed no self-administration of medication assessment was completed to determine the resident’s ability to safely self-administer antifungal powder or antifungal lotion. On 8/19/25 at 1:28 PM Staff 18 (CNA) confirmed Resident 35 had both antifungal powder and lotion on her/his bedside table and removed the medicated powder and lotion from the room for disposal. Staff 18 stated residents should not have medications at the bedside. On 8/19/25 at 1:38 PM Staff 19 (RN) stated residents were assessed and needed physician orders in place for self-administration of medications. Staff 19 acknowledged medications should not be kept at the bedside for self-administration without an assessment. On 8/19/25 at 2:22 PM Staff 3 (RNCM) acknowledged residents required an assessment for safe self-administration of medications and treatments. Staff 3 confirmed Resident 35 was not assessed to safely self-administer medications, and the medications were not left in her/his room. 2. Resident 46 was admitted to the facility in 2/2025 with diagnoses including bipolar disorder (a mood disorder). Resident 46’s 5/21/25 Quarterly MDS indicated the resident had moderate cognitive impairment. Observations on 8/18/25 at 9:40 AM and 8/19/25 at 1:10 PM revealed Resident 46 had antifungal powder on her/his bedside table. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 46’s health record revealed no self-administration of medication assessment was completed to determine the resident’s ability to safely self-administer antifungal powder. On 8/19/25 at 1:13 PM Staff 20 (CNA) confirmed Resident 46 had antifungal powder on her/his bedside table. Staff 20 stated the facility kept antifungal powder at the bedside for residents who needed it, and staff helped them apply the powder as part of their care. On 8/19/25 at 1:38 PM Staff 19 (RN) stated residents were assessed and needed physician orders in place for self-administration of medications. Staff 19 acknowledged medications should not be kept at the bedside for self-administration without an assessment. On 8/19/25 at 2:22 PM Staff 3 (RNCM) acknowledged residents required an assessment for safe self-administration of medications and treatments. Staff 3 confirmed Resident 46 was not assessed to safely self-administer medications, and the medications were not left in her/his room. 3. Resident 31 was admitted to the facility in 12/2021 with diagnoses including dementia and gastroparesis (a stomach disorder that significantly slows or stops the movement of food from the stomach to the small intestine). Resident 31's 12/30/24 Annual MDS indicated she/he had moderate cognitive impairment. No evidence was found in Resident 31's health record to indicate she/he had a doctor's order or was approved to self-administer medications. On 8/18/25 at 10:15 AM a plastic cup containing a white powder was observed on Resident 31's bedside table. The words, Gold Bond medicated powder were written on the outside of the cup. On 8/18/25 at 10:15 AM Resident 31 stated she/he did not know who left the powder on her/his table. 8/18/2025 10:55 AM Staff 19 (RN) acknowledged the cup of powder at Resident 31's bedside and stated she was aware Resident 31 had an order for the powder but stated she/he did not have an order to self-administer the medicated powder. On 8/19/25 at 1:20 PM Staff 41 (CNA) stated she notified the medication aide or the nurse if she saw medications at a resident's bedside. Staff 41 stated she didn't usually see pills, but she did see nystatin powder (a topical antifungal medication used to treat skin and mucocutaneous fungal infections) and barrier creams on residents' bedside tables. On 8/19/25 at 1:38 PM Staff 19 stated residents were not allowed to keep medications in their rooms without having a physician's order and without being evaluated to self-administer the medication. Staff 19 stated it was unsafe because residents might use them incorrectly or ingest them. On 8/19/25 at 1:46 PM Staff 3 (RNCM) stated it was a safety concern for Resident 31 to have medications in their rooms without a physician's order and without an evaluation to ensure the resident was able to self-administer the medication safely. Staff 3 stated if she found medications in Resident 31's room she would remove the medications, request an order from the physician and complete a self-administration evaluation.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review it was determined the facility failed to protect the resident's right to be free from abuse by another resident for 1 of 7 sampled residents (#17) reviewed for abuse. This placed residents at risk for abuse. Findings include:Resident 17 was admitted to the facility in 12/2017 with diagnoses including vascular dementia (impaired reasoning, planning, judgment, memory and other thought processes caused by impaired blood flow to the brain) and peripheral vascular disease (a condition that affects the blood vessels outside of the heart and brain and primarily involves the narrowing or blockage of arteries that supply blood to the legs, arms, stomach, or kidneys).Resident 17's 12/31/24 annual MDS indicated a BIMS was not completed due to her/his refusal to participate in the assessment.Resident 17's cognition care plan indicated she/he refused to participate in a standardized cognitive evaluation and staff were unable to assess her/his level of cognition.Resident 63 was admitted to the facility in 3/2025 with diagnoses including a femur fracture and Alzheimer's disease.Resident 63's 3/13/25 admission / Medicare - 5 Day assessment revealed she/he had severe cognitive impairment and exhibited physical and verbal behaviors on a daily basis. A cognitive loss / dementia CAA completed with her/his admission assessment indicated she/he scratched and hit staff members and her/his goal was to return to a memory care facility after completing her/his therapy goals.A review of Resident 63's care plan revealed staff were to monitor her/him for acts of physical aggression toward staff.A FRI completed on 3/31/25 revealed Resident 63 wandered into Resident 17's room on 3/30/25 and told her/him to get out of her/his bed then pinched Resident 17 on the wrist which caused two small bruises to Resident 17's wrist. The FRI concluded the facility substantiated abuse of Resident 17 by Resident 63.On 4/1/25 Staff 5 (Social Services Director) submitted a written statement with a summary of the incident. In her statement, Staff 5 indicated Resident 17 pointed to the bruises on her/his wrist and stated, Look what that crazy [resident] did and Just keep [her/him] away from me. In her statement, Staff 5 concluded resident-to-resident abuse occurred. On 8/21/25 at 7:45 AM Staff 38 (CNA) stated he remembered the incident and Resident 17 showed him the bruises on her/his wrist the day after the incident. Staff 38 stated he and other CNAs kept Resident 17 and Resident 63 separate after the incident on 3/30/25 to avoid any other incidents.On 8/21/25 at 8:17 AM Staff 5 stated she remembered the incident and staff placed a temporary stop sign on Resident 17's door to discourage Resident 63 from entering without permission and possibly having another incident.On 8/21/25 at 2:57 PM Staff 32 (CNA) stated she remembered the incident and said Resident 63 was pretty aggressive and wandered into Resident 17's room, grabbed her/him and wouldn't let her/him go.On 8/22/25 at 9:09 AM Staff 40 (CNA) stated he remembered the incident on 3/30/25 and heard Resident 17 hollering out and found her/him crying in her/his doorway with Resident 63. Staff 40 stated he helped Resident 63 back to her/his room while a nurse assessed Resident 17. Staff 40 stated Resident 63 swatted at but never hit other residents when she/he was uncomfortable with them. Staff 40 stated Resident 63 did not have a one-on-one at the time of the incident and he did not know if she/he ever had a one-on-on after the incident.On 8/22/25 at 11:32 AM Staff 1 (Administrator) acknowledged the incident on 3/30/25 with Resident 17 and Resident 63. Staff 1 stated all residents should be free from aggressive behaviors, including pinching. Staff 1 stated he expected staff to monitor residents who demonstrate behaviors to limit the possibility of them escalating to the level of abuse.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview and record review it was determined the facility failed to ensure residents were appropriately assessed for the use of a physical restraint for 1 of 1 sampled resident (#30) reviewed for restraints. This placed residents at risk for restricted freedom of movement and a decline in physical functioning. Findings include:Resident 30 was admitted to the facility in 2024 with diagnoses including a stroke.The facility's Physical Restraints and Enablers/Devices Policy and Procedure dated 8/1/24 indicated restraints were used only to treat a resident's medical symptom, protect the resident' safety, and assist the resident in attaining or maintaining the highest practicable level of physical and psychosocial well-being. If determined a resident had symptoms necessitating the use of a physical or mechanical device, an evaluation was completed prior to the device being initiated, annually and upon a change of condition. The effect, not the intent is evaluated to determine if the device was a restraint or an enabler. Devices may include but not limited to, self-releasing seatbelts.A 5/13/25 Annual MDS revealed Resident 30 was impaired on one side and utilized a motorized wheelchair. A review of Resident 30's electronic medical record revealed no assessment was completed regarding the use of a self-releasing seatbelt when Resident 30 used her/his motorized wheelchair.Random observations from 9:00 AM to 4:30 PM on 8/18/25 through 8/28/25 revealed Resident 30 moved throughout the facility in her/his motorized wheelchair and wore a seatbelt positioned across her/his lower abdomen.On 8/18/25 at 2:16 PM, Resident 30 stated she/he used her/his motorized wheelchair at all times to maneuver around the facility and had a seatbelt. Resident 30 stated she/he was unsure whether anyone assessed her/him for the safety of the seatbelt.On 8/20/25 at 1:51 PM, Staff 23 (CNA), and at 2:44 PM, Staff 24 (CNA) both stated Resident 30 had a seatbelt for safety when in her/his wheelchair. Both stated the resident could not latch the seatbelt independently but could safely unlatch/release the seatbelt latch on her/his own.On 8/20/25 at 7:00 PM, Staff 19 (RN) and on 8/21/25 at 11:53 AM, Staff 15 (RN) both stated Resident 30 used a motorized wheelchair to maneuver around the facility and had a seatbelt for safety. Both stated an assessment was required because the seatbelt could be considered a restraint if Resident 30 was unable to latch and unlatch it independently. Both were unsure if an assessment was completed.On 8/21/25 at 2:42 PM, Staff 3(RNCM) stated Resident 30 required the seatbelt for safety when she/he was in her/his motorized wheelchair and no assessment was completed until requested on 8/18/25. Staff 3 stated the assessment was to ensure the seatbelt was not considered a restraint and the resident was able to latch and unlatch it independently. On 8/22/25 at 9:34 AM, Staff 2 (DNS) stated she was unaware Resident 30 utilized a seatbelt in her/his wheelchair, and she completed an assessment on 8/19/25 to ensure the resident was able to latch and unlatch the seatbelt safely. Staff 2 stated she expected staff to complete assessments quarterly to ensure the seatbelt was not functioning as a restraint.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to ensure a clinical rational for administering a psychotropic medication for 1 of 5 sampled residents (#9) reviewed for medications. This placed residents at increased risk for adverse consequence of antipsychotic medication. Findings include:Resident 9 was admitted to the facility on 6/2025 with diagnosis including Parkinsons and difficulty walking.A review of Drugs.com - Prescription Drug Information revealed the following common side effects of trazodone included drowsiness, dizziness and tiredness. After a single dose in a healthy adult, trazadone was mostly eliminated from the system within one to three days. The half-life of trazadone was approximately five to 13 hours, meaning every five to 13 hours, the blood concentration of the drug decreased by 50 percent. The elimination half-life of a medication referred to the time required for its blood levels to be reduced by half. Factors such as metabolism, age, health status, weight and the amount and frequency of the drug taken influenced the rate at which the body cleared the medication. The Psychotropic Drug Use, Dementia Cognitive Loss and Fall CAA dated 6/11/25 revealed Resident 9 was administered trazodone (an antidepressant) 50 mg at bedtime. No diagnosis was documented in the orders or located in the hospital records and clarification was needed. Witness 4 (Family Member) signed consent for the use of trazodone and indicated the medication was being used for sleep; however, no diagnosis was associated with the order. The resident was a fall risk and had severe cognitive impairment and metabolic encephalopathy (a condition in which the brain was not functioning properly due to a chemical imbalance.) A physician order dated 6/10/25 directed staff to administer trazodone 50 mg at bedtime for.A review of Resident 9's 6/2025 and 7/2025 MARs revealed the resident received trazodone at bedtime from 6/10/25 through 7/10/25 (29 days).A review of Resident 9's clinical record and Un-Witnessed Fall event investigations from 6/20/25 through 7/8/25 revealed the following:-6/20/25 at 2:10 PM Resident 9 experienced an unwitnessed fall in the bathroom due to self-transferring. No injury was sustained.-6/22/25 at 6:08 AM Resident 9 rolled out of bed and was found on the floor after attempting to self-transfer. No injuries were sustained.-6/26/25 at 3:14 AM Resident was found on the floor. The bed was in the highest position, although it had been in the lowest position 15 minutes earlier. A fall mat was in place and the resident had non-skid socks on. Resident 9 complained of right hip pain, had a bruise on the head and sustained a small skin tear. The resident was sent out to the hospital and returned later that shift with no major injuries or new orders.-6/27/25 at 2:20 PM Resident 9 was found sitting on the bathroom floor with her/his back against the wheelchair, positioned as if attempting to self-transfer. No injuries were sustained.-7/6/25 at 1:30 PM Resident 9 was found on the floor, she/he slid out of bed. No injuries were sustained.-7/8/25 at 4:20 PM Resident 9 was found on the floor, next to her/his bed. No injuries were sustained.A Progress Note dated 6/25/25 at 1:27 PM, by Staff 3 (RNCM) revealed she reviewed the hospital records for proper diagnosis for use of trazodone and no new diagnosis was located. The note indicated, Given to med records to upload.A 7/10/25 Order Note revealed a verbal order from the provider to discontinue the trazodone related to no diagnosis for use of the medication and to monitor. A review of Resident 9's clinical record revealed trazadone was discontinued on 7/10/25 (29 days later).On 8/20/25 at 10:17 AM, Staff 38 (CNA) and at 2:32 PM, Staff 24 (CNA) and Staff 28 (CNA), all stated Resident 9 was a fall risk, experienced confusion, required two-person assistance for transfers and was dependent for ADL care. Staff stated while on the 200 hall, the resident had fallen multiple times. Staff 24 and Staff 28 stated the resident was difficult to monitor on the 200 hall because where the resident was located. Staff further stated Resident 9 had not fallen since being moved to the 100 hall. On 8/21/25 at 3:08 PM Staff 3 (RNCM) stated she reviewed orders upon admission to ensure all medications had appropriate diagnosis and indications for use. She used a drug manual or google to research potential side effects. Staff 3 sated the 6/25/25 note created was intended to alert the provider the resident lacked a diagnosis or clinical rational for trazadone use. Staff 3 confirmed this was overlooked and not followed up on. Staff 3 acknowledged Resident 9 continued to receive trazadone until it was discontinued on 7/10/25 and acknowledged the resident experienced multiple falls from 6/20/25 through 7/8/25. Staff 3 recognized the potential correlation of between trazadone and the resident's unwitnessed falls.On 8/21/25 at 8:35 PM Staff 45 (LPN) stated she worked with Resident 9 on the 200 hall and confirmed the resident was a fall risk. Staff 45 stated the trazodone was administered but was unsure whether there was an appropriate diagnosis or an order for its use. Staff 45 stated it was the responsibility of office people to ensure residents had appropriate diagnoses for psychotropic medications. Staff 45 stated trazodone could cause drowsiness and potentially

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review it was determined the facility failed to complete a person-centered care plan related to ostomy care for 1 of 1 sampled resident (#30) reviewed for bowel and bladder. This placed residents at risk for infections and lack of ADL care. Findings include:Resident 30 was admitted to the facility in 2024 with diagnoses including a stroke and anxiety.A Care Plan dated 5/6/24 revealed Resident 30 had an alteration in gastro-intestinal status including colostomy. Interventions included bowel-colostomy, give medications as ordered, monitor and document effectiveness. The care plan did not include monitoring for signs/symptoms of potential infection, leakage, or how to clean the stoma (surgically created, opening on the surface of the abdomen) and peristomal (area of skin surrounding an ostomy stoma, where the artificial appliance is attached to collect bodily waste) skin.A 5/13/25 Annual MDS revealed Resident 30 had a BIMS score of 15 which indicated she/he was cognitively intact. The resident had an indwelling catheter and an ostomy (an appliance worn over the stoma which is a surgically created opening on the abdomens surface to collect feces).A review of the 7/2025 and 8/2025 TARs revealed Resident 30 was to have her/his colostomy bag and wafer (an adhesive backed disc with a hole for the stoma that sticks to the skin around it, creating a seal) changed every five to seven days and as needed. On 8/18/25 at 2:16 PM, Resident 30 stated she/he required assistance with her/his ostomy care and some staff did not know what to do or were slow to respond. This resulted in the ostomy bag exploding and caused irritation to the stoma, which the resident found concerning.On 8/20/25 at 1:51 PM, Staff 23 (CNA) and at 2:44 PM, Staff 24 (CNA) both stated Resident 30 required one-person assistance with ostomy care and it was important to clean around the stoma. Staff stated she/he was very particular about her/his ostomy care and directed how often the ostomy bag should be changed or cleaned. Both indicated CNAs were to review the care plan prior to starting their shift. On 8/20/25 at 7:00 PM, Staff 19 (RN) stated she provided Resident 30's ostomy care because the resident was cautious and concerned about infection and leakage. Staff 19 stated CNAs were expected to report signs or symptoms of leakage or other concerns related to the resident's ostomy care. Staff 19 stated CNAs were responsible for reviewing the care plan to ensure appropriate care and monitoring of the ostomy. On 8/21/25 at 11:53 AM, Staff 15 stated she provided Resident 30's ostomy care every seven days because the residents skin became irritated easily. Staff 15 stated CNAs were to report any concerns related to leakage or signs and symptoms of infection to the nurse. Staff 15 indicated all staff were responsible for reviewing the resident's care plan.On 8/21/25 at 2:42 PM, Staff 3 (RNCM) stated she was responsible for the care plan and was unaware Resident 30 had concerns related to her/his ostomy care. Staff 3 reviewed the care plan and acknowledged interventions related to Resident 30's ostomy care were lacking. On 8/22/25 at 9:34 AM, Staff 2 (DNS) stated she reviewed Resident 30's colostomy care plan and expected staff to ensure the care plan reflected appropriate interventions for ostomy care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review the facility failed to prevent an avoidable fall for 1 of 4 sampled residents (#3) reviewed for falls. This placed residents at risk for injury. Findings include:Resident 3 was admitted to the facility in 3/2025 with diagnoses including a stroke and dysphagia (difficulty swallowing foods and liquids). Resident 3's 3/18/25 admission MDS indicated the resident had severe cognitive impairment and was dependent for all care needs including toileting and bed mobility. Resident 3's 6/7/25 fall investigation report indicated at approximately 4:00 AM, the nurse was on a break when Resident 3 was found in her/his room, on the floor, between the bed and the wall. The report indicated Staff 27 (CNA) changed Resident 3's brief around 3:30 AM and at 4:00 AM, Staff 26 (CNA) heard the resident yelling and crying and found Resident 3 on the floor. Resident 3's bed was not pushed back against the wall as it should have been, and the facility only had two CNAs scheduled for 50 residents. There were no reported injuries and Resident 3 refused to be transported to the hospital for an evaluation. On 8/18/25 at 3:54 PM and 8/19/25 at 2:22 PM, Witness 2 (Family Member) stated on 6/7/25, Resident 3 was found between the bed and wall and the resident had to beat her/his head against the wall to get the attention of staff. Witness 2 stated Resident 3 fell because a CNA did not push the resident's bed back against the wall after providing care. Witness 2 stated the facility did not usually have enough staff and on 6/7/25 night shift, when Resident 3 fell, the facility was short-staffed. On 8/20/25 at 8:58 AM, Staff 27 reported around 3:30 AM, he changed Resident 3's brief and about a half hour later, I was told of a STAT [immediately] fall regarding Resident 3. Staff 27 stated there were two CNA staff working and two CNAs were not enough to meet the needs of the residents because the facility is big and the acuity of the residents was too high for only two CNA staff. On 8/20/25 at 9:10 AM, Staff 26 stated Resident 3 was considered a high fall risk. She reported Staff 27 changed Resident 3's brief around 3:30 AM and upon finishing, Staff 27 did not push the resident's bed back against the wall. Staff 26 stated about a half hour later, she heard Resident 3 yelling and crying and found her/him on the floor between the bed and wall, in a fetal position. Staff 26 stated there were only two CNAs working in the facility for 50 residents thus they were not able to meet the acuity needs of the residents. On 8/21/25 at 11:12 AM, Staff 2 (DNS) and Staff 3 (RNCM) confirmed Resident 3 had a fall on 6/7/25 because CNA staff did not push her/his bed back against the wall after providing care. Staff 2 and Staff 3 verified the facility only had two CNA staff on night shift and the facility was short-staffed. Refer to F725.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined the facility failed to ensure there was sufficient nursing staff available to provide the necessary care and services to meet residents' needs in 1 of 1 facility reviewed for staffing. This placed residents at risk for lack of ADL care needs. Findings include: On 8/18/25 the facility had a census of 53 residents. On 8/20/25, Staff 1 (Administrator) provided a list of residents who:-Required two-person mechanical lift transfers: 12;-Required two-person extensive or total assistance for bathing: 1; -Required two-person extensive or total assistance for toileting: 10;-Required two-person extensive or total assistance for dressing: 1;-Required one-to-one feeding assistance: 7;-Were considered high fall risks: 30;-Were considered at risk for elopement: 4 and -Required bariatric care (body mass index greater than 40): 10. 1. Resident 3 was admitted to the facility in 3/2025 with diagnoses including a stroke and dysphagia (difficulty swallowing foods and liquids). Resident 3's 3/18/25 admission MDS indicated the resident had severe cognitive impairment and was dependent for all care needs including toileting and bed mobility. Resident 3's 6/7/25 fall investigation report indicated the resident had a fall on 6/7/25, night shift and only two CNA staff were on shift when Resident 3 fell. On 8/18/25 at 3:54 PM and 8/19/25 at 2:22 PM, Witness 2 (Family Member) stated the facility did not usually have enough staff scheduled and on 6/7/25 night shift, when Resident 3 fell, the facility was short-staffed. On 8/20/25 at 8:58 AM, Staff 27 (CNA) reported he worked on 6/7/25 with Staff 26 (CNA) and stated two CNAs were not enough staff to meet the needs of the residents because the facility is big and the acuity of the residents was too high for only two CNA staff. On 8/20/25 at 9:10 AM, Staff 26 stated on 6/7/25 there were only two CNAs working in the facility for 50 residents thus they were not able to meet the acuity needs of the residents. On 8/21/25 at 11:12 AM, Staff 2 (DNS) and Staff 3 (RNCM) verified on 6/7/25, the facility only had two CNA staff on night shift, and confirmed the facility was short-staffed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Post Acute	707 SW 37th Street Pendleton, OR 97801

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Random observations from 8/18/25 through 8/22/25 between the hours of 7:30 AM and 10:00 PM revealed the following: -No call light monitors were observed in the residents' units/hallways. There was one call light monitor located at the nurses' station which was inaudible. On 8/19/25 at 2:54 PM, the call light monitor at the nurses' station was not functioning. -On 8/19/25 at 2:54 PM, room [ROOM NUMBER]'s call light was activated for 34 minutes and room [ROOM NUMBER]'s call light was activated for 30 minutes. -CNA staff were to carry electronic call light activation devices, and some CNAs did not have electronic call light activation devices on their person when randomly asked to produce the device.-On multiple occasions during day and evening shift observations, CNA staff were difficult to find. -On 8/19/25 at 3:01 PM, a resident on the 200 unit was visible from the hallway, naked and was hollering, gotta moment? Multiple staff walked by the resident's room without stopping to assist the resident. -On 8/20/25 at 8:22 PM, a resident was outside in the parking lot with a CNA, yelling help me, help me, help me. -On 8/20/25 at 8:33 PM, room [ROOM NUMBER]'s call light was activated for 47 minutes, room [ROOM NUMBER]'s call light was activated for 30 minutes, room [ROOM NUMBER]'s call light was activated for 28 minutes and room [ROOM NUMBER]'s call light was activated for 22 minutes. -On 8/20/25 at 8:55 PM, two residents were in wheelchairs on the 300 unit and verbalized they were waiting for assistance to go to bed for at least 45 minutes. On 8/18/25 at 9:45 AM, Resident 26 stated she/he required two staff to assist with all ADL care. Resident 26 stated it took anywhere from 30 minutes to two hours to find two staff available to assist with her/his ADL care. Resident 26 stated the night shift was the worst shift. On 8/18/25 at 11:03 AM, Resident 20 stated she/he was incontinent and sometimes it took what feels like hours before staff were available to assist her/him. On 8/18/25 at 1:13 PM, Resident 4 stated call light response times were frequently slow, especially during mealtimes. Resident 4 stated she/he sometimes waited up to two hours for assistance. Resident 4 stated she/he feared something might happen to her/him and nobody would be available to help. On 8/18/25 at 1:21 PM, Resident 18 stated last week it took staff 58 minutes to assist her/him. Resident 18 stated staff often answered her/his call light, said they would be right back and never returned. On 8/20/25 at 9:41 AM, Staff 22 (CNA) stated the facility had many CNA staff who called off, frequently. Staff 22 stated the facility was chronically low staffed which resulted in residents' not receiving proper care. Staff 22 stated during times when the facility was short staffed, residents' showers were missed, call light response times were longer, and staff had to stay past their shift to complete all of their work. On 8/20/25 at 10:18 AM, Staff 15 (RN) stated there were often days when CNAs called off or were habitually late which resulted in inadequate staffing. Staff 15 stated the facility did not staff according to the acuity needs of residents. On 8/20/25 at 10:45 AM, Staff 28 (CNA) stated staffing was horrible and there was often not enough staff scheduled to meet the acuity needs of the residents. Staff 28 stated there was a resident with behavioral needs who often tried to get out of the facility or tried to kiss other residents so the resident required a lot of time to supervise. Staff 28 stated there were times when showers were missed, CNA staff could not complete their rounds or turn residents every two hours and staff were unable to take lunches or breaks. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/25 at 8:43 PM, Staff 32 (CNA) stated care was difficult at times due to the number of bariatric residents. On 8/20/25 at 9:30 PM, Staff 35 (CMA) stated staffing on the weekends was the worst. Staff 35 stated call light response times were often long because CNAs were unable to get to them timely. Staff 35 stated there were a lot of behavioral need residents and residents at a high risk for falls. Staff 35 stated showers were missed, at times. On 8/21/25 at 10:01 AM, Staff 25 (Regional Director of Rehabilitation) confirmed some residents did not receive SLP and OT rehabilitation services timely or at the frequency determined to be necessary because they did not have adequate SLP and OT staff coverage. On 8/21/25 at 11:35 AM, Staff 11 (Human Resources/Payroll/Staffing) stated she was responsible for staffing and staffing needs were based on the State mandatory minimum CNA staffing ratios and not according to the acuity needs of residents. Staff 11 stated she was aware the facility resident acuity levels were high. Staff 11 stated many staff called off and it was difficult to get agency coverage. Staff 28 confirmed the facility was not able to staff to the acuity needs of the residents because they did not have enough employees and agency staff were not available. Staff 28 also verified weekend staffing was especially difficult. 3. Resident 30 was admitted to the facility in 2024 with diagnoses including a stroke and anxiety. A 5/13/25 Annual MDS revealed Resident 30 had a BIMS score of 15, which indicated she/he was cognitively intact, had an indwelling catheter and an ostomy (an appliance worn over the stoma, which is a surgically created opening on the abdomen surface to collect feces). On 8/18/25 at 2:16 PM, Resident 30 stated she/he required assistance with ostomy care and on multiple occasions, her/his ostomy bag had blown out due to insufficient staffing, resulting in a mess on her/him and while in bed. Resident 30 stated she/he was upset and frustrated because there is never enough staff on evening shift. On 8/19/25 at 10:02 AM, Staff 18 (CNA) stated Resident 30 required assistance with the resident's ostomy care and at times the resident's ostomy bag had blown out due to staffing shortages. On 8/20/25 at 1:51 PM, Staff 23 (CNA) stated Resident 30 required assistance with ostomy care and there had been instances when staff were unable to get to respond in a timely manner, resulting in the resident's bag exploding. Staff 23 stated the resident voiced concerns within the past two weeks regarding inadequate ostomy care during evening shift. On 8/20/25 at 7:00 PM, Staff 19 (RN) stated Resident 30 was particular about her/his ostomy care due to concerns about odor and fear of leakage or bursting. Staff 19 stated within the past last two weeks, the resident's ostomy bag exploded during the evening shift due to lack of staff. Staff 19 stated Resident 30 was very upset after experiencing a bowel movement all over herself/himself and in her/his bed. Staff 19 stated this was a direct result of inadequate staffing based on resident acuity. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 8/20/25 at 8:36 PM, Resident 30 was observed in her/his motorized wheelchair just outside her/his doorway and stated her/his call light was on for approximately 20 minutes and the resident was waiting for assistance to go to bed. Resident 30 stated there never was enough staff on evening shift. At 9:11 PM (approximately 60 minutes later) Staff 33 (CNA) assisted the resident to bed. On 8/21/25 at 2:42 PM, Staff 3 (RNCM) stated she was unaware of Resident 30's concerns regarding timely ostomy care. Staff 3 stated staff were expected to answer call lights within five to 10 minutes. Staff 3 acknowledged ongoing staffing challenges and confirmed the facility had residents with high acuity needs. On 8/22/25 at 9:34 AM, Staff 2 (DNS) stated she expected all staff to respond to call lights within 15 minutes and acknowledged the facility struggled to maintain appropriate staffing levels. Staff 2 acknowledged many residents with high acuity care needs. 4. Resident 9 was admitted to the facility on 6/2025 with diagnosis including Parkinsons and difficulty walking. The Dementia Cognitive Loss CAA dated 6/11/25 revealed Resident 9 had severe cognitive impairment and metabolic encephalopathy (the brain is not functioning properly due to a chemical imbalance.) On 8/20/25 at 2:32 PM, Staff 24 (CNA) and Staff 28 (CNA) both stated Resident 9 was a fall risk, experienced confusion, required two-person assistance with transfers and was dependent on staff for all ADL care needs. Staff 24 and Staff 28 indicated the facility was often severely understaffed during evenings and weekends and both were assigned beyond the state minimum staffing ratios. On 8/20/25 at 8:33 PM, Resident 9 was observed up in her/his wheelchair sitting outside her/his room. At 8:45 PM, Staff 31 (LPN) spoke with Resident 9 who stated she/he needed to use the bathroom and wanted to go to bed. Staff 31 requested assistance for Resident 9 and was informed the assigned CNA was providing a shower to another resident. At 9:16 PM, two staff members assisted Resident 9 into her/his bedroom and closed the door. At 9:33 PM, (approximately 45 minutes later), the resident was in bed, with the bed in the lowest position and call light within reach. On 8/20/25 at 9:36 PM Staff 47 (CNA) stated evening shifts were rough. Staff 47 stated it was difficult assisting residents and responding to call lights in a timely manner. Staff 47 stated residents were upset due to long wait times and inadequate staffing. Staff 47 stated multiple residents in the facility required two-person assistance or were fully dependent on staff for ADL care needs. On 8/21/25 at 2:42 PM, Staff 3 (RNCM) stated staff were expected to answer call lights within five to 10 minutes. Staff 3 acknowledged staffing concerns and the facility had residents with high acuity needs. On 8/22/25 at 9:34 AM, Staff 2 (DNS) stated she expected all staff to answer call lights within 15 minutes and acknowledged the ongoing challenges in maintaining appropriate staffing levels. Staff 2 acknowledged the facility had many residents with high acuity care needs. 5. During a Resident Council meeting on 8/20/25 at 1:05 PM, attendees expressed concerns regarding long response times from staff during the evening shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident Council meeting minutes from 5/22/25 concerns with call lights not being answered and staff not coming back after initial response. Resident Council meeting minutes from 6/2025 revealed concerns with staff taking two hours to answer call lights. On 8/22/25 at 9:34 AM, Staff 2 (DNS) stated she expected all staff to answer call lights within 15 minutes and acknowledged the ongoing challenges in maintaining appropriate staffing levels. Staff 2 acknowledged the facility had many residents with high acuity care needs.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on interview and record review it was determined the facility failed to ensure the Direct Care Staff Daily Report (DCSDR) postings were accurate and complete for 13 of 77 days reviewed for staffing. This placed residents and the public at risk for inaccurate staffing information. Findings include:A review of the facility's DCSDRs revealed the following: From 6/1/25 through 8/18/25, 77 days were reviewed and revealed 13 days when licensed nurse staff hours were inaccurate or the postings had missing/incomplete information on 6/5/25, 6/6/25, 6/15/25, 7/6/25, 7/8/25, 7/25/25, 8/1/25, 8/3/25, 8/4/25, 8/11/25, 8/12/25, 8/16/25 and 8/17/25. On 8/21/25 at 11:25 AM, Staff 11 (Human Resources/Payroll/Staffing Coordinator) reviewed the 6/1/25 through 8/18/25 DCSDRs and verified the reports were inaccurate or incomplete on the days identified.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review it was determined the facility failed to ensure pharmacy recommendations were addressed by the physician for 1 of 5 sampled residents (#9) reviewed for unnecessary medications. This placed residents at risk for adverse side effects of medications. Findings include:Resident 9 was admitted to the facility on 6/2025 with diagnosis including Parkinsons and difficulty walking. Resident 9's 6/2025 and 7/2025 Pharmacy Recommendation and Review indicated Resident 9 a new order for trazodone (an antidepressant medication) with an unknown diagnosis. The recommendation was given to provide a diagnosis for the new psychotropic medication.A review of Resident 9's 6/2025 and 7/2025 MARs revealed the resident received trazodone at bedtime from 6/10/25 through 7/10/25 (29 days). On 8/22/25 at 8:33 AM and 10:28 AM, Staff 39 (Pharmacist) stated residents were reviewed monthly to ensure they had appropriate clinical diagnoses for use of all medications, including psychotropics. Staff 39 stated Resident 9 did not have an appropriate diagnosis or clinical rationale for the use of trazodone. On 8/22/25 at 9:46 AM, 11:00 AM, and 11:47 AM, Staff 2 (DNS) stated she noticed a lag in ensuring clinical rationales were documented for the use of medications, including psychotropics. Staff 2 acknowledged the pharmacy recommendation regarding Resident 9 was not followed up on in a timely manner. Staff 2 stated she expected RNCMs to follow up with the physician to ensure recommendation were implemented.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review it was determined the facility failed to maintain a medication error rate of less than 5 percent. There were eight errors out of 30 opportunities resulting in a 26. 67 percent error rate. This placed residents at risk for adverse medication side effects and pain. Findings include: Resident 9 was admitted to the facility in 6/2025 with diagnoses including Parkinson's Disease (a disorder of the central nervous system). Resident 9's 6/11/25 admission MDS indicated the resident had significant cognitive impairment.Resident 9's 8/2025 MAR indicated Resident 9 was to receive:- Carbidopa/levodopa (a medication for Parkinson's Disease) 25-100 mg TID - Allopurinol (medication for gout) 300 mg in the morning- Aspirin (medication for irregular heart rate) 81 mg in the morning- Cholecalciferol (a vitamin) 25 mcg in the morning- Finasteride (medication for an enlarged prostate) 5 mg in the morning- Senna (a laxative) 8.6 mg BID- Furosemide (medication for fluid retention) 40 mg in the morning- Metoprolol (medication for irregular heart rate) ER 100 mg in the morningThe 8/20/25 MAR indicated the morning medications were due at 7:00 AM and were not administered until 9:06 AM. On 8/20/25 at 9:06 AM Staff 15 (RN) was observed to administer the morning doses of carbidopa/levodopa, allopurinol, aspirin, cholecalciferol, finasteride, senna, furosemide and metoprolol to Resident 9. On 8/20/25 at 9:12 AM Staff 15 acknowledged the late administration of carbidopa/levodopa, allopurinol, aspirin, cholecalciferol, finasteride, senna, furosemide and metoprolol for Resident 9. On 8/20/25 Staff 2 (DNS) acknowledged the identified medication errors due to the late administration of morning medications for Resident 9 on 8/20/25.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review it was determined the facility failed to ensure proper storage temperatures were logged and maintained for 1 of 1 medication refrigerator reviewed for medication storage. This placed residents at risk for degradation and reduced efficacy of biologicals and medication. Findings include:The 7/2025 and 8/2025 medication refrigerator temperature logs indicated the temperatures were to be logged twice daily and the temperatures were to be between 36 F and 46 F. The temperature logs indicated the following:-15 occasions when the temperature was checked one time or less.-12 occasions when the temperature was less than 36 F. On 8/19/25 at 2:53 PM Staff 17 (RN) stated refrigerator temperatures should be checked and documented on the log by a nurse twice daily to ensure it was completed and temperatures were in the appropriate range. On 8/20/25 at 8:04 AM Staff 15 (RN) stated refrigerator temperatures should be checked and recorded on the log by a nurse every shift. Staff 15 stated if the temperature was out of range, she/he would adjust the thermometer and recheck later. On 8/20/25 at 10:29 AM Staff 7 (Environmental Services Director) stated the medication refrigerator temperatures should be monitored and recorded by nurses each shift and they were to notify him of readings that were out of range. Staff 7 stated the refrigerator temperature was running low over the past couple of weeks and acknowledged there were multiple temperature readings below 36 F.On 8/20/25 at 11:21 AM Staff 2 (DNS) acknowledged the identified dates on the logs when the temperatures were out of range and the temperatures were not checked twice daily.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and record review it was determined the facility failed to store and handle food in a sanitary manner in 1 of 1 kitchen and 2 of 2 snack refrigerators. This placed residents at risk for food borne illness. Findings include:The facility's Personal Hygiene, Food Handling and Storage Policy dated 8/2024 revealed the following:- Individuals handling food must practice good personal hygiene to minimize the risk of contaminating food and causing foodborne illness. Food storage areas shall be maintained in a clean, safe, and sanitary manner.- Hairnets, hats, or coverings are required at all times, [including] beard guards/masks for facial hair longer than trimmed eyebrows. Hair must be fully contained; only functional accessories allowed.- Food Services, or other designated staff, will maintain clean food storage areas at all times. - Food shall be rotated as delivered and used in a First In, First Out method. Items will be dated on receipt to facilitate this procedure.- Prepared food stored in the refrigerator until service shall be dated with an expiration date. Such food will be tightly sealed with plastic wrap, foil, or a lid.- Cold foods will be maintained at temperatures of 40*F or below. Hot foods or potentially hazardous food will leave the kitchen or steam table at 140*F or above. Frozen foods will be stored at 0*F or below at all times.- The Food Services Manager, or his/her designee, will check refrigerators and freezers daily for proper temperatures. The Food Services Manager will maintain records of such information.The facility's Resident Food from Outside Source Policy dated 8/2024 revealed the following: - Refrigerated food items from an outside source is stored in a container with the following information on it: date product received, name of product, resident name and room number. - Refrigerated foods that are unlabeled or undated, when noted, is discarded. 1. The following items were observed in the facility's kitchen and pantry areas from 8/18/25 at 9:00 AM and 9:56 AM:Freezers:- Unlabeled lightly colored patties with no date.- Two empty dinner plates.- Unlabeled and undated frozen waffles in bags. - Multiple bags of unlabeled and undated orange vegetable sticks.- Unlabeled and undated yellow patties in a bag. - A bag of opened corn, not labeled or dated.- Garlic toast with plastic bag twisted, not labeled or dated.- Freezer burn on a frozen piece of meat, partially opened out of its plastic wrap.- A product labeled turkey leg, dated 4/19, with a hole in its plastic wrap with freezer burn.- Freezer temperature logs were reviewed from 8/1/25 through 8/17/25 and there were 28 instances where the temperature logs were blank. Refrigerators: - Empty apple juice pitcher dated 8/15.- Refrigerator temperature logs were reviewed from 8/1/25 through 8/17/25 and there were 11 instances where the temperature logs were blank.Pantry:- Four bags of rice crispy cereal in a plastic container with no date or expiration on the bags. The label on container read: R. Bran 5/29 and Cheerio 5/29. - Two bags of rice crispy cereal sat on a shelf with no label, date, or label of expiration.- One dented can of tomato sauce was on a shelf.General kitchen: - Stainless-steel container partially filled with cornbread sitting on kitchen counter. The foil did not completely cover the product and was not labeled or dated. On 8/18/25 at 9:45AM, Staff 12 (Dietary Manager) stated she did not know what the unlabeled items in the freezers were. She acknowledged the freezer burned items and stated she expected staff to wrap meat properly for storage and any items with freezer burn to be thrown out. Staff 12 acknowledged the empty pitcher in the refrigerator and stated she expected for empty pitchers that formerly contained juice to be cleaned and sanitized before the next fill and not stored in refrigerators. Staff 12 acknowledged the unlabeled bags of rice crispy cereal and dent in the can of tomato sauce. She stated she expected all items to be labeled upon receipt, labeled when opened, and expiration date to be visible. She stated the dented can was expected to be taken out of the pantry. Staff 12 stated the unlabeled and undated cornbread sitting on the kitchen counter was not served with breakfast on 8/18/25 and was not sure how long it had been sitting on the counter and acknowledged it should have been thrown away. Staff 12 acknowledged the lack of recorded temperature logs for the freezers and refrigerators and stated she expected for temperature logs to be recorded twice a day in order to maintain appropriate food temperatures for residents. Staff 12 stated there was no system in place to audit the refrigerators, freezers, and pantry for cleanliness and quality. She stated staff had taken items out of boxes and placed them into refrigerators, freezers, and onto shelves with no labeling system in place.2. On 8/18/25 at 9:42 AM, the snack refrigerator in the pantry area contained a partially filled pitcher of liquid dated 7/20.On 8/19/25 at 2:58 PM, the snack refrigerator in the ice machine room had a container of wrinkled, unlabeled and undated cherub tomatoes. There were no temperature logs on or around the refrigerator.On 8/18/25 at 9:45 AM, Staff 12 (Dietary Manager) acknowledged the pitcher of liquid dated 7/20 and stated she expected for dietary staff to remove pitchers from the refrigerator within five days of the labeled date. She stated there

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on observation, interview and record review it was determined the facility failed to provide physical, occupational and speech therapy services as ordered for 3 of 3 sampled residents (#s 3, 26 and 60) reviewed for rehabilitation services. This placed residents at risk for a decline in functional abilities and diminished quality of life. Findings include: The Stroke Foundation, What to Expect From a Stroke, dated 2023, explained stroke rehabilitation (PT, OT and SLP) was the therapy and activities that drive recovery by helping to re-learn ways of doing things affected by a stroke. It aimed to stimulate the brain to change and adapt. By creating new pathways, a person could learn to use other parts of the brain to recover function of those parts affected by the stroke. Improvement after a stroke can continue for years but for many people it's quickest in the first six months. 1. Resident 3 was admitted to the facility in 3/2025 with diagnoses including a stroke, hemiparesis/hemiplegia (the loss of ability to move part or most of the body) and dysphagia (difficulty swallowing foods and liquids). Resident 3's 3/12/25 Hospital Discharge Summary indicated the resident had a stroke which resulted in a prolonged hospitalization complicated by dysphagia. On 3/7/25, Resident 3 had a PEG tube (a type of feeding tube inserted into the stomach and used for individuals when unable to swallow food or liquids) surgically placed due to her/his inability to swallow. Resident 3's 3/12/25 Discharge to Facility Physician Order's prescribed SLP and OT evaluations and treatment upon admission to the facility. The resident continued to require PEG tube feedings for nutrition. Resident 3's 3/18/25 admission MDS indicated the resident had severe cognitive impairment, was unable to eat by mouth and was dependent for all needed care. Resident 3's Speech Therapy Medicare SLP Evaluation and Treatment revealed the resident was evaluated on 3/28/25, 16 days after the resident was admitted to the facility. The evaluation determined Resident 3 needed SLP treatment two times a week. Resident 3's 3/2025 and 4/2025 SLP Service Matrix Log (a record used to track therapy visits) indicated the resident did not receive her/his twice weekly SLP therapy on 4/5/25 through 4/11/25 and 4/12/25 through 4/18/25. The resident was not provided the prescribed SLP treatments on two of four weeks during 4/2025. Resident 3's Occupational Therapy Medicare OT Evaluation and Treatment revealed the resident was evaluated on 3/31/25, 19 days after the resident was admitted to the facility. The evaluation determined Resident 3 needed OT treatment two times a week. Resident 3's 3/2025 and 4/2025 OT Service Matrix Log indicated the resident did not receive her/his twice weekly OT therapy on 4/6/25 through 4/13/25 and 4/14/25 through 4/20/25. The resident was not provided the prescribed OT treatments on two of four weeks during 4/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385201	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Post Acute	707 SW 37th Street Pendleton, OR 97801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multiple random observations from 8/17/25 through 8/22/25 between the hours of 7:30 AM and 10:00 PM revealed Resident 3 had right-sided hemiparesis with reduced functional movement of her/his right arm or hand and reduced movement of her/his right leg. Resident 3 had a PEG tube in place. On 8/18/25 at 3:54 PM, Witness 2 (Family Member) reported Resident 3 did not receive timely SLP or OT services as ordered because the facility lacked therapy staff. On 8/21/25 at 10:01 AM, Staff 25 (Regional Director of Rehabilitation) reviewed Resident 3's SLP and OT therapy services for 3/2025 and 4/2025. Staff 25 confirmed the resident did not receive SLP and OT services in a timely manner and at the frequency determined to be necessary because they did not have adequate SLP and OT staffing. On 8/22/25 at 10:09 AM, Staff 1 (Administrator) confirmed Resident 3's SLP and OT services were not provided as prescribed, and he expected therapy to be provided as ordered and in a timely manner. 2. Resident 26 was admitted to the facility in 6/2025 with diagnoses including chronic pain syndrome and bilateral hip arthritis. Resident 26's 6/11/25 Annual MDS indicated the resident had no cognitive impairment. Resident 26 required substantial/maximal assistance for toileting, dressing, personal hygiene, bed mobility and was dependent for chair to bed transfers. A 7/6/25 Progress Note indicated Resident 26 was transferred to the hospital due to nausea, a headache and shoulder pain. A 7/11/25 Progress Note indicated Resident 26 returned from the hospital. Resident 26's 7/11/25 Skilled Nursing Facility Transfer Orders prescribed PT and OT evaluation and management. A review of Resident 26's electronic health record revealed no evidence PT and OT evaluations were completed. On 8/18/25 at 9:45 AM, Resident 26 stated she/he was supposed to receive therapy services, did not receive them and was unsure why no therapy was provided. On 8/21/25 at 10:01 AM, Staff 25 (Regional Director of Rehabilitation) confirmed Resident 26 had PT and OT orders written on 7/11/25 and no PT or OT services were provided. Staff 25 was unsure why the PT and OT orders were missed. 3. Resident 60 was admitted to the facility in 2/2024 with diagnoses including hemiplegia (paralysis of one side of the body) and aphasia (loss of the ability to speak or understand spoken language as a result of brain damage). Resident 60's 2/29/24 admission MDS revealed he was cognitively intact, usually understood speech, sometimes made herself/himself understood, received 26-50% of her/his nutrition and hydration via feeding tube, used a wheelchair for ambulation and was dependent for transfers. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 60's signed orders dated 2/26/24 revealed she/he was to be evaluated and treated as necessary by Physical Therapy (PT) and Occupational Therapy (OT). Orders dated 3/5/24 also revealed she/he was to be evaluated and treated as necessary for diet advancement by a Speech-Language Pathologist (SLP). Resident 60's care plan included a goal dated 2/23/24 to work with therapies to increase strength and reinforce cognitive strategies. Resident 60's therapy evaluation notes revealed she/he was evaluated by PT, OT and SLP who recommended the following therapy schedules:-PT: three days per week-OT: five days per week-SLP: three days per week Resident 60's therapy schedule for the week of 2/25/24 through 3/2/24 revealed the following:-Received two of three PT sessions-Received one of five OT sessions-Received two of three SLP sessions Resident 60's therapy schedule for the week of 3/3/24 through 3/9/24 revealed the following:-Received one of three PT sessions Resident 60's therapy schedule for the week of 3/10/24 through 3/16/24 revealed the following:-Received two of three PT sessions On 8/20/25 at 10:29 AM Staff 13 (Administrative Assistant / Director of Rehabilitation) acknowledged the missed therapy dates and stated PT was out sick during the weeks of 2/25/24 through 3/2/24 and 3/10/24 through 3/16/24 and was not able to complete the scheduled sessions. Staff 13 was unaware of the reason for the other missed therapy sessions. On 8/21/25 at 10:12 AM Staff 25 (Regional Director of Rehabilitation) acknowledged the missed therapy sessions and lack of documentation regarding the reason the sessions were missed. He stated therapists sometimes documented in the electronic record and sometimes they did not. On 8/21/25 at 3:09 PM Witness 6 (Family Member) stated Resident 60 was supposed to receive therapy every day and the staff guaranteed Resident 60 would receive therapy three to four days a week. On 8/22/25 at 11:32 AM Staff 1 (Administrator) acknowledged Resident 60's missed therapy sessions and stated he expected all residents to receive skilled therapy as ordered. Refer to F725.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review it was determined the facility failed to ensure enhanced barrier precautions were implemented for 1 of 3 sampled residents (#9) reviewed for infection control. This placed residents at risk for transmission of infection. Findings include: The facility's Transmission Based Precautions Policy and Procedure dated 8/1/24 indicated the following:-To implement Transmission-Based Precautions for residents known to be, or suspected of being, infected with infectious agents.-Enhanced Barrier Precautions (EBP) when a person is colonized with a Multi-Drug-Resistant Organism or the status of colonization is unknown, enhanced barrier precautions are utilized, per CDC guidance, to reduce the risk of spread of and MDRO (actual colonized or potential). -Personal caring for a resident on EBP wears gloves and a gown. Prior to leaving the resident's room, gown and gloves are removed and hand hygiene performed. EBP is used with residents with a urinary catheter during the following situations: dressing, transferring, providing hygiene and changing briefs or assisting with toileting.Resident 9 was admitted to the facility in 6/2025 with diagnosis including Parkinsons and difficulty walking.A 6/11/25 admission MDS indicated the resident was dependent on staff for all ADL care needs and had a catheter.On 8/20/25 at 9:49 AM, Resident 9's door was observed to have a sign which indicated she/he was on EBP. The resident was sitting in her/his wheelchair when Staff 38 (CNA) escorted resident to her/his room because she/he needed to use the commode. Staff 38 left and returned with the sit-to-stand device, which was positioned in front of the resident. Staff 38 did not perform hand hygiene or don gloves or gown. Staff 38 placed the resident's catheter bag on the floor, then picked it up and hung it on the side of the commode. Staff 38 requested assistance and Staff 16 (CMA/CNA) entered the room donned gloves but no gown. Both staff assisted the resident to the commode. Staff 16 removed his gloves and performed hand hygiene at the sink. Staff 38 left the room without performing hand hygiene.On 8/20/25 at 10:03 AM, Staff 16 stated when a resident was placed on EBP, staff were required to don gown and gloves before providing ADL care. Staff 16 acknowledged he did not don a gown. On 8/20/25 at 10:17 AM, Staff 38 stated Resident 9 had a catheter, required two-person assistance for transfers and was on EBP. Staff 38 acknowledged he did not don gown or gloves prior to assisting the resident onto the commode and had not performed appropriate hand hygiene. Staff 38 stated the catheter bag should not have been placed on the floor. On 8/22/25 at 9:46 AM, and 11:00 AM, Staff 2 (DNS) stated all residents who were placed on EBP required staff to follow appropriate infection control practices, hand hygiene and confirmed Resident 9's catheter bag was not to be placed on the floor.